Medicare
Home Health Agency Manual

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 302 **Date: JULY 26, 2002**

CHANGE REQUEST N/A

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
204.1 - 204.2 (Cont.)	13.18 – 14.4 (6 pp.)	13.18 – 14.4 (6 pp.)

CLARIFICATION – EFFECTIVE DATE: Not Applicable

Section 204.1, Confined to the Home, clarifies homebound criteria, including absences for an infrequent or relatively short duration. The additional material clarifies current policy governing homebound.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

203.2 Impact of Other Available Caregivers and Other Available Coverage on Medicare Coverage of Home Health Services.--Where the Medicare criteria for coverage of home health services are met, patients are entitled by law to coverage of reasonable and necessary home health services. Therefore, a patient is entitled to have the reasonable and necessary services reimbursed by Medicare without regard to whether there is someone available to furnish the services. However, where a family member or other person is or will be providing services that adequately meet the patient's needs, it would not be reasonable and necessary for HHA personnel to furnish such services. Ordinarily it can be presumed that there is no able and willing person to provide the services being rendered by the HHA unless the patient or family indicates otherwise and objects to the provision of the services by the HHA, or the HHA has first hand knowledge to the contrary.

EXAMPLE: A patient, who lives with an adult daughter and otherwise qualifies for Medicare coverage of home health services, requires the assistance of a home health aide for bathing and assistance with an exercise program to improve endurance. The daughter is unwilling to bathe her elderly father and assist with the exercise program. Home health aide services to provide these services would be reasonable and necessary.

Similarly, a patient is entitled to have the reasonable and necessary home health services reimbursed by Medicare even if the patient would qualify for institutional care (e.g., hospital care or skilled nursing facility care).

EXAMPLE: A patient who is discharged from a hospital with a diagnosis of osteomyelitis and requires continuation of the IV antibiotic therapy that was begun in the hospital was found to meet the criteria for Medicare coverage of skilled nursing facility services. If the patient also meets the qualifying criteria for coverage of home health services, payment may be made for the reasonable and necessary home health services the patient needs, notwithstanding the availability of coverage in a skilled nursing facility.

Medicare payment should be made for reasonable and necessary home health services where the patient is also receiving supplemental services that do not meet Medicare's definition of skilled nursing care or home health aide services.

EXAMPLE: A patient who needs skilled nursing care on an intermittent basis also hires a licensed practical (vocational) nurse to provide nighttime assistance while family members sleep. The care provided by the nurse, as respite to the family members, does not require the skills of a licensed nurse as defined in §205.1 and, therefore, has no impact on the patient's eligibility for Medicare payment of home health services even though another third party insurer may pay for that nursing care.

203.3 Use of Utilization Screens and "Rules of Thumb".--Medicare recognizes that determinations of whether home health services are reasonable and necessary must be based on an assessment of each patient's individual care needs. Therefore, denial of services based on numerical utilization screens, diagnostic screens, diagnosis or specific treatment norms is not appropriate.

204. CONDITIONS THE PATIENT MUST MEET TO QUALIFY FOR COVERAGE OF HOME HEALTH SERVICES

To qualify for Medicare coverage of any home health services, the patient must meet each of the criteria described in this section. Patients who meet each of these criteria are eligible to have payment made on their behalf for the services discussed in §§205 and 206.

204.1 Confined to the Home.--

A. Patient Confined to The Home.--In order for a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the patient is confined to his/her home. (See §240.1.) An individual does not have to be bedridden to be considered as confined to the home. However, the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort. If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment. Absences attributable to the need to receive health care treatment include, but are not limited to, attendance at adult day centers to receive medical care, ongoing receipt of outpatient kidney dialysis, and the receipt of outpatient chemotherapy or radiation therapy. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in a State shall not disqualify an individual from being considered to be confined to his home. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of an infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. It is expected that in most instances, absences from the home that occur will be for the purpose of receiving health care treatment. However, occasional absences from the home for nonmedical purposes, e.g., an occasional trip to the barber, a walk around the block, a drive, attendance at a family reunion, funeral, graduation, or other infrequent or unique event would not necessitate a finding that the patient is not homebound if the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home. The examples provided above are not all-inclusive and are meant to be illustrative of the kinds of infrequent or unique events a patient may attend.

Generally speaking, a patient will be considered to be homebound if he/she has a condition due to an illness or injury that restricts his/her ability to leave his/her place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person or if leaving home is medically contraindicated. Some examples of homebound patients that illustrate the factors used to determine whether a homebound condition exists would be: (1) a patient paralyzed from a stroke who is confined to a wheelchair or requires the aid of crutches in order to walk; (2) a patient who is blind or senile and requires the assistance of another person to leave his/her residence; (3) a patient who has lost the use of his/her upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and requires the assistance of another individual to leave his/her residence; (4) a patient who has just returned from a hospital stay involving surgery suffering from resultant weakness and pain and, therefore, his/her actions may be restricted by his/her physician to certain specified and limited activities such as getting out of bed only for a specified period of time, walking stairs only once a day, etc.; (5) a patient with arteriosclerotic heart disease of such severity that he/she must avoid all stress and physical activity; (6) a patient with a psychiatric problem if the illness is manifested in part by a refusal to leave home or is of such a nature that it would not be considered safe to leave home unattended, even if he/she has no physical limitations; and (7) a patient in the late stages of ALS or a neurodegenerative disabilities.

In determining whether the patient has the general inability to leave the home and leaves the home only infrequently or for periods of short duration, it is necessary (as is the case in determining whether skilled nursing services are intermittent) to look at the patient's condition over a period of time rather than for short periods within the home health stay. For example, a patient may leave the home (under the conditions described above, e.g, with severe and taxing effort, with the assistance of others) more frequently during a short period when, for example, the presence of visiting relatives provides a unique opportunity for such absences, than is normally the case. So long as the patient's overall condition and experience is such that he or she meets these qualifications, he or she should be considered confined to the home.

The aged person who does not often travel from home because of feebleness and insecurity brought on by advanced age would not be considered confined to the home for purposes of receiving home health services unless he/she meets one of the above conditions. A patient who requires skilled care must also be determined to be confined to the home in order for home health services to be covered.

Although a patient must be confined to the home to be eligible for covered home health services, some services cannot be provided at the patient's residence because equipment is required that cannot be made available there. If the services required by a patient involve the use of such equipment, the HHA may make arrangements or contract with a hospital, skilled nursing facility, or a rehabilitation center to provide these services on an outpatient basis. (See §§200.2 and 206.5.) However, even in these situations, for the services to be covered as home health services, the patient must be considered confined to his/her home; and to receive such outpatient services a homebound patient will generally require the use of supportive devices, special transportation, or the assistance of another person to travel to the appropriate facility.

If a question is raised as to whether a patient is confined to the home, the HHA will be asked to furnish the intermediary with the information necessary to establish that the patient is homebound as defined above.

B. Patient's Place of Residence.--A patient's residence is wherever he/she makes his/her home. This may be his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, an institution may not be considered a patient's home if the institution meets the requirements of §§1861(e)(1) or 1819 (a)(1) of the Act. Included in this group are hospitals and skilled nursing facilities, as well as most nursing facilities under Medicaid.

Thus, if a patient is in an institution or distinct part of an institution identified above, the patient is not entitled to have payment made for home health services under either Part A or Part B since these institutions may not be considered his/her residence. When a patient remains in a participating SNF following his/her discharge from active care, the facility may not be considered his/her residence for purposes of home health coverage.

A patient may have more than one home and the Medicare rules do not prohibit a patient from having one or more places of residence. A patient, under a Medicare home health plan of care, who resides in more than one place of residence during an episode of Medicare covered home health services will not disqualify the patient's homebound status for purposes of eligibility. For example, a person may reside in a principal home and also a second vacation home, mobile home or the home of a caretaker relative. The fact that the patient resides in more than one home and, as a result, must transit from one to the other, is not in itself, an indication that the patient is not homebound. The requirements of homebound must be met at each location (e.g., considerable taxing effort etc).

1. Assisted Living Facilities, Group Homes & Personal Care Homes.--An individual may be "confined to the home" for purposes of Medicare coverage of home health services if he or she resides in an institution that is not primarily engaged in providing to inpatients diagnostic and therapeutic services for medical diagnosis, treatment, care of disabled or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or skilled nursing care or related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, sick, or disabled persons. If it is determined that the assisted living facility (also called personal care homes, group homes, etc.) in which the individuals reside are not primarily engaged in providing the above services, then Medicare will cover reasonable and necessary home health care furnished to these individuals.

If it is determined that the services furnished by the home health agency are duplicative of services furnished by an assisted living facility (also called personal care homes, group homes, etc.) when provision of such care is required of the facility under State licensure requirements, claims for such services should be denied under §1862(a)(1)(A) of the Act. Section 1862(a)(1)(A) excludes services that are not necessary for the diagnosis or treatment of illness or injury or to improve the functioning

of a malformed body member from Medicare coverage. Services to people who already have access to appropriate care from a willing caregiver would not be considered to be reasonable and necessary to the treatment of the individual's illness or injury.

From the Medicare perspective, individuals who reside in assisted living facilities may be eligible for coverage of Medicare home health services. A major consideration is the location of the individual within the assisted living facility in terms of the level and type of care that is provided.

Medicare coverage would not be an optional substitute for the services that a facility that is required to provide by law to its patients or where the services are included in the base contract of the facility. An individual's choice to reside in such a facility is also a choice to accept the services it holds itself out as offering to its patients.

2. Day Care Centers and Patient's Place of Residence.--The law does not permit an HHA to furnish a Medicare covered billable visit to a patient under a home health plan of care outside his or her home, except in those limited circumstances where the patient needs to use medical equipment that is too cumbersome to bring to the home. Section 507 of the Medicare, Medicaid and SCHIP Beneficiary Improvement and Protection Act (BIPA) of 2000 amended §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act governing home health eligibility. The new law did not amend §1861(m) of the Act governing coverage. Section 1861(m) of the Act stipulates that home health services provided to a patient be provided to the patient on a visiting basis in a place of residence used as the individual's home. A licensed/certified day care center does not meet the definition of a place of residence.

3. State Licensure/Certification of Day Care Facilities.--In order to meet the requirements of §507 of BIPA, an adult day care center must be either licensed or certified by the State or accredited by a private accrediting body. State licensure or certification as an adult day care facility must be based on State interpretations of its process. For example, we understand that several States do not license adult day care facilities as a whole, but do certify some entities as Medicaid certified centers for purposes of providing adult day care under the Medicaid home and community based waiver program. We believe that it is the responsibility of the State to determine the necessary criteria for "State certification" in such a situation. A State could determine that Medicaid certification is an acceptable standard and consider its Medicaid certified adult day care facilities to be "State certified". On the other hand, a State could determine Medicaid certification to be insufficient and require other conditions to be met before the adult day care facility is considered "State certified".

4. Determination of the Therapeutic, Medical or Psychosocial Treatment of the Patient at the Day Care Facility.--We do not believe it is the obligation of the HHA to determine whether the adult day care facility is providing psychosocial treatment, but only to assure that the adult day care center is licensed/certified by the State or accrediting body. We believe that the intent of the law, in extending the homebound exception status to attendance at such adult day care facilities, recognizes that they ordinarily furnish psychosocial services.

204.2 Services Are Provided Under a Plan of Care Established and Approved by a Physician.--

A. Content of the Plan of Care.--The plan of care must contain all pertinent diagnoses, including the patient's mental status, the types of services, supplies, and equipment required, the frequency of visits to be made, prognosis, rehabilitation potential, functional limitations, activities permitted nutritional requirements, all medications and treatments, safety measures to protect against injury, instructions for timely discharge or referral, and any additional items the HHA or physician choose to include.

NOTE: This manual uses the term "plan of care" to refer to the medical treatment plan established by the treating physician with the assistance of the home health care nurse. Although

CMS previously used the term "plan of treatment," the Omnibus Budget Reconciliation Act of 1987 replaced that term with "plan of care" without a change in definition. CMS anticipates that a discipline-oriented plan of care will be established, where appropriate, by an HHA nurse regarding nursing and home health aide services and by skilled therapists regarding specific therapy treatment. These care plans may be incorporated in the physician's plan of care or separately prepared.

B. Specificity of Orders.--The orders on the plan of care must specify the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services.

EXAMPLE: SN x 7/wk x 1 wk; 3/wk x 4 wk; 2/wk x 3 wk, (skilled nursing visits 7 times per week for 1 week; three times per week for 4 weeks; and two times per week for 3 weeks) for skilled observation and evaluation of the surgical site, for teaching sterile dressing changes and to perform sterile dressing changes. The sterile change consists of (detail of procedure).

Orders for care may indicate a specific range in the frequency of visits to ensure that the most appropriate level of service is provided during the 60 day episode to home health patients. When a range of visits is ordered, the upper limit of the range is considered the specific frequency.

EXAMPLE: SN x 2-4/wk x 4 wk; 1-2/wk x 4 wk for skilled observation and evaluation of the surgical site. . . .

Orders for services to be furnished "as needed" or "PRN" must be accompanied by a description of the patient's medical signs and symptoms that would occasion a visit and a specific limit on the number of those visits to be made under the order before an additional physician order would have to be obtained.

C. Who Signs the Plan of Care.--The physician who signs the plan of care must be qualified to sign the physician certification as described in 42 CFR 424.22.

D. Timeliness of Signature.--

1. Initial Percentage Payment.--If a physician signed plan of care is not available at the beginning of the episode, the HHA may submit a RAP for the initial percentage payment based on physician verbal orders OR a referral prescribing detailed orders for the services to be rendered that is signed and dated by the physician. If the RAP submission is based on physician verbal orders, the verbal order must be recorded in the plan of care, include a description of the patient's condition and the services to be provided by the home health agency, include an attestation (relating to the physician's orders and the date received per 42 CFR 409.43), and the plan of care is copied and immediately submitted to the physician. A billable visit must be rendered prior to the submission of a RAP.

2. Final Percentage Payment.--The plan of care must be signed and dated by a physician as described who meets the certification and recertification requirements of §424.22 and before the claim for each episode for services is submitted for the final percentage payment. Any changes in the plan of care must be signed and dated by a physician.

E. Use of Oral (Verbal) Orders.--When services are furnished based on a physician's oral order, the orders may be accepted and put in writing by personnel authorized to do so by applicable State and Federal laws and regulations, as well as by the HHA's internal policies. The orders must be signed and dated with the date of receipt by the registered nurse or qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social worker) responsible for furnishing or supervising the ordered services. The orders may be signed by the supervising registered nurse or qualified therapist after the services have been rendered, as long as

HHA personnel who receive the oral orders notify that nurse or therapist before the service is rendered. Thus, the rendering of a service that is based on an oral order would not be delayed pending signature of the supervising nurse or therapist. Oral orders must be countersigned and dated by the physician before the HHA bills for the care in the same way as the plan of care.

(1) Services that are provided from the beginning of the 60 day episode certification period based on a request for anticipated payment and before the physician signs the plan of care are considered to be provided under a plan of care established and approved by the physician where there is an oral order for the care prior to rendering the services which is documented in the medical record and where the services are included in a signed plan of care.

EXAMPLE: The HHA acquires an oral order for IV medication administration for a patient to be performed on August 1. The HHA provides the IV medication administration August 1 and evaluates the patient's need for continued care. The physician signs the plan of care for the IV medication administration on August 15. Since the HHA had acquired an oral order prior to the delivery of services, the visit is considered to be provided under a plan of care established and approved by the physician.

(2) Services that are provided in the subsequent 60 day episode certification period are considered to be provided under the plan of care of the subsequent 60 day episode where there is an oral order before the services provided in the subsequent period are furnished and the order is reflected in the medical record. However, services that are provided after the expiration of a plan of care, but before the acquisition of an oral order or a signed plan of care, cannot be considered to be provided under a plan of care.

EXAMPLE 1: The patient is under a plan of care in which the physician orders IV medication administration every 2 weeks. The last day covered by the initial plan of care is July 31. The patient's next IV medication administration is scheduled for August 5th and the physician signs the plan of care for the new period on August 1st. The IV medication administration on August 5th was provided under a plan of care established and approved by the physician. The episode begins on the 61st day regardless of the date of the first covered visit.

EXAMPLE 2: The patient is under a plan of care in which the physician orders IV medication administration every 2 weeks. The last day covered by the plan of care is July 31. The patient's next IV medication administration is scheduled for August 5th and the physician does not sign the plan of care until August 6th. The HHA acquires an oral order for the IV medication administration before the August 5th visit, and therefore the visit is considered to be provided under a plan of care established and approved by the physician. The episode begins on the 61st day regardless of the date of the first covered visit.

(3) Any increase in the frequency of services or addition of new services during a certification period must be authorized by a physician by way of a written or oral order prior to the provision of the increased or additional services.

F. Frequency of Review of the Plan of Care.--The plan of care must be reviewed and signed by the physician who established the plan of care, in consultation with HHA professional personnel, at least every 60 days. Each review of a patient's plan of care must contain the signature of the physician and the date of review.

G. Facsimile Signatures.--The plan of care or oral order may be transmitted by facsimile machine. The HHA is not required to have the original signature on file. However, the HHA is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature.